

‘From Health Crisis to Development Crisis: A Challenge to the Development Approach to HIV/AIDS.’

By: Sara O’Shaughnessy

Supervisor: Prof. Elisabeth Abergel

June 15th, 2007

Faculty of Environmental Studies
York University
Toronto, ON

Abstract

Over the past decade, the HIV/AIDS crisis has been reconceptualised from a health problem, with an emphasis on the behavioural and biomedical aspects, to a development problem, in which major development organisations have taken on a predominant leadership role. This reconceptualisation has been praised for increasing awareness of the wider contextual factors impacting on HIV/AIDS; however, it has not yet provided effective policies and solutions for this crisis. This paper argues that certain characteristics of mainstream development are at variance with the multiple dimensions and demands of the crisis, including a bias towards economic factors, an ignorance of the political context and a top-down organisational structure.

Introduction

In the first two decades of the HIV/AIDS pandemic in southern Africa, the global response regarded the disease primarily as a *health* problem. AIDS has recently undergone a reconceptualisation by academics, civil society, governments and relevant donor institutions alike as a *development* problem, one that bears significant repercussions for the status of nearly all aspects of social and economic wellbeing in the region. Just as the narrow perception of AIDS as a health problem had considerable influence on the nature of the response to the crisis, this recent shift in thinking toward prioritising the development concerns is also producing a specific discourse that is shaping the governance of and response to the HIV/AIDS crisis.

In particular, it is important to consider who is driving this paradigm shift in HIV/AIDS thinking, and whose specific interests are subsequently being placed at the forefront of the global governance of the HIV/AIDS crisis. Another fundamental question is whether the practical manifestations of this reconceptualisation, including the types of approaches and priorities of interventions, will sufficiently address and overcome the underlying causes of vulnerability and reduce the gravity of the impacts of HIV/AIDS in the region.

This paper critically examines the implications of the reconceptualisation of AIDS as a development problem in relation to both the preceding discourse of AIDS as a health problem, and to the current nature of development itself. Of particular concern is the ongoing institutionalisation and production of knowledge about HIV/AIDS, influenced heavily by neoliberalism, which not only transcends the paradigm shift but is also reinforced by current development thinking. Specifically, this paper criticises the singular focus on socio-economic contributors to vulnerability within this new discourse, the apolitical nature of this approach and the influence of donor interests within the current development model.

The evolution of the global discourse of HIV/AIDS

It is now widely recognised that HIV/AIDS is not simply a disease that attacks the body. It is a pandemic that is most powerful and destructive in the poorest and most marginalised parts of the world, and requires an innovative and persistent global response to reduce vulnerability to both the disease and its devastating impacts. The inclusion of halting and reversing the spread of HIV/AIDS by 2015 as the sixth Millennium Development Goal is demonstrative of the fact that HIV/AIDS is becoming increasingly recognised as a development crisis. Connections between the pandemic and all aspects of economic and social development are easily made. At the macro-level, the growth of national economies is being undercut by labour and productivity losses resulting from AIDS-related deaths or illnesses (World Bank 1999, 9; see also Dixon et al. 2001; Arndt and Lewis 2001). Rural livelihoods are facing multiple unique and seemingly insurmountable HIV/AIDS-related challenges, such as the loss of the most productive members of the household and subsequent losses of essential knowledge transfer between generations (Haddad & Gillespie 2001: 493-494). Possibly most shocking of all the impacts of HIV/AIDS is the pernicious reversal of previous development gains, such as advances in education and child survival rates (World Bank 1999, 8).

At the present stage of the global HIV/AIDS pandemic, the existence of a relationship between the crisis and development is clearly evident, although still not adequately understood. However, this reconceptualisation of AIDS as a development problem is only recent. The inception of the HIV/AIDS pandemic in southern Africa in the mid-1980s occurred within a decade of the initial outbreak of the disease in Western world. Yet by that point, as O'Manique indicates, a highly institutionalised system of knowledge and a biomedical/health discourse of HIV/AIDS had already developed from the Western experience in which the disease was construed almost entirely as a health crisis, isolated from the broader socioeconomic, political and cultural context (2004a, 19). The centre of knowledge production and authority on the AIDS crisis in southern Africa was located outside of the communities of people living with HIV/AIDS. African governments, organisations and communities were constructed as takers of knowledge in this system, not as a source of information and innovation (2004, 19). Though it was

recognised that HIV/AIDS in the West initially spread within certain social groups such as the gay community and intravenous drug users, Western epidemiologists initially attributed this clustering to biological, rather than wider social factors. In Africa, the outbreak did not occur within these same social groups, yet that distinction did not instigate new research agendas. Instead, abstractions from the spread and impact of the disease in the West were the central source of knowledge on the emerging crisis in Africa (Fredland 1998, 564).

Thus, the research priorities defined by assumptions drawn from the Western experience of HIV/AIDS were concentrated on biomedical and behavioural change approaches to treatment and prevention (O'Manique 2004a, 26). According to O'Manique:

The main question guiding research on AIDS in Africa was: what is distinct about the heterosexual spread of HIV in African countries? Scientists initially looked to parallels with the western experience to guide research on the epidemiology of AIDS. Sexual behaviour became the main focus of research. (2004a, 26)

Because of the hegemonic forces of Western medical science in the production of knowledge about HIV/AIDS, the wider context of sexual behaviour, the ways it is shaped by political, socioeconomic and cultural forces, and the possibility of other factors contributing to vulnerability in southern Africa were not substantially integrated in this system of knowledge about HIV/AIDS. This, arguably, contributed to the lack of a successful, early response to prevent the crisis tailored specifically to the context and resources in the region. The few African countries that did mount successful early prevention campaigns, such as Uganda and Senegal, did so from a distinctly Africa-centric perspective, which capitalised on their specific existing resources and recognised the wider impacts of the disease (Putzel 2004, 1134).

Often, irrational and irresponsible stereotypes regarding African sexuality as the cause of the rapid spread and large scale of the HIV/AIDS pandemic in the region underpinned many prevention efforts. Nana K. Poku provides one of the most convincing arguments exposing the absurdity of attributing the scale of the pandemic solely to sexual factors:

But how much sex are we talking about that would produce, in absence of other factors, prevalence of HIV in Botswana that is over fifty times that of the United States, eighty times that of France and 1,000 times that of Cuba? Clearly, sexual behaviour is an important factor in the transmission of sexually transmitted disease. But sexual behaviour alone cannot explain HIV prevalence as high as 25 per cent of the adult population in some African countries and less than 1 per cent in the developed world. (2005, 3-4)

Moreover, the very generalised nature of the epidemic in SSA means that HIV/AIDS is a threat within all aspects of society, even where such *risky* behaviour like prostitution does not necessarily exist. For instance, the UNDP reports that in the Ndola region of Zambia, 27% of young married women are infected with HIV/AIDS, whereas only 16% of their sexually active unmarried peers are HIV-positive, indicating that even behaviours not typically considered *risky*, such as marriage, can contribute to vulnerability. (UNDP 2005, 39)

According to O'Manique, the construction of AIDS as a health problem occurred during the "global consolidation" of the neoliberal ideology. Neoliberalism's compatibility with and influence on this perspective is perceptible "to the extent that the focus is on the isolated individual, abstracted from broader social relations" (2004a, 19). By constructing the cause of the AIDS crisis as a matter of individual behaviours and emphasising only the health-related consequences, the role of global social, economic and political inequalities are muted. Moreover, this discourse also distracts from the fact that the main promoters of neoliberalism in southern Africa, the World Bank and the IMF, required many African governments to cut-back on social and health service provisioning as part of structural adjustment programmes to pay back looming debts just as the HIV/AIDS crisis was emerging (Poku 2005, 9). Impact mitigation did not figure into the strategies to combat the disease. Instead, individuals and households were left to themselves to manage the heavy emotional and financial burdens of the disease (O'Manique 2004b, 52). Although a few highly visionary works predicted early on the devastating social and economic impacts of the pandemic that lay well beyond the scope of public health (see Barnett and Blaikie 1992; Gillespie 1989), it was only once these impacts became tragically and overwhelmingly visible that they were recognised within the global governance of HIV/AIDS.

The irreconcilable weaknesses of the responses to HIV/AIDS in southern Africa dictated by the discourse of the disease as a health problem were eventually all too apparent. A wide variety of cultural, socioeconomic and political factors constrained the effectiveness of behavioural change approaches to prevention, and the magnitude of pandemic rapidly increased. The biomedical approaches to treatment have proven largely incongruous with the low capacity of health care systems in the region. As yet, no cure had been found, and the drug treatments that have the potential to delay the onset of AIDS, which are now widely available in the West, are still inaccessible to great majority of HIV-positive Africans. Thus, the benefits that have resulted from the AIDS as health problem discourse have been largely irrelevant for Africa. Given the mounting scale of the pandemic today, this approach essentially failed to curb the spread of HIV/AIDS and to address its devastating impacts. Over 24 million people in sub-Saharan Africa are currently estimated to be infected HIV, and roughly 2 million people die each year from AIDS-related causes (UNAIDS 2006, 13).

The implications of constructing AIDS as a development problem

In the face of the staggering evidence of the unique context of HIV/AIDS in sub-Saharan Africa, a new response recognising AIDS in the context of development is beginning to emerge. The shift towards thinking about the pandemic as a development problem is an important step towards grasping the fact that the AIDS is much more than simply a disease that affects the physical body. The reconceptualisation of HIV/AIDS as a development problem has received considerable support for providing insight into the impacts of the pandemic that emanate from the specific socioeconomic context in which people exist. Undoubtedly, this insight has been crucial to the formulation of a new direction for the global governance of the problem, which involves the cooperation of many development institutions and takes into account people's wellbeing as an objective of interventions.

A number of key events have helped solidify this paradigm shift. In 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was established with the involvement of several wide ranging UN agencies and replaced the World Health Organisation's Global Programme on AIDS as the locus of UN operations and policy on HIV/AIDS. Another turning point in the global reconceptualisation of HIV/AIDS in southern Africa was the declaration by the World Bank in its 1999 report on HIV/AIDS and development to scale up its commitment to combating HIV/AIDS, which has been frequently identified as the most defining event of this paradigm shift (Putzel 2004, 1130; Boone and Batsell 2001, 4). UNAIDS and the World Bank, along with other multi- and bilateral development and donor agencies like the Gates Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria have become the leading authorities in the current global governance of AIDS. These organisations are the driving force behind the discourse of HIV/AIDS as a development problem. They are central to the production of knowledge on HIV/AIDS, particularly UNAIDS which provides key estimates on the status of the pandemic worldwide, and suggests best practice approaches derived from successful programmes and projects throughout the world.

UNAIDS and the World Bank, along with other multi- and bilateral development and donor agencies like USAID, the Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United States' President's Emergency Plan for AIDS Relief, have become the leading authorities in the current global governance of AIDS. According to Putzel, the World Bank has created an "organizational template" that has come to dominate the international drive against HIV/AIDS in the developing world," which is equally supported by UNAIDS and other donor agencies (Putzel 2004, 1131). This template disassembles the health-oriented strategies of the previous approach and advocates for a decentralised, multisectoral National HIV/AIDS Committees (NACs) involving widespread participation by civil society (Putzel 2004, 1131). The much-needed financial resources at the disposal of these donor agencies have ensured widespread adoption of this approach and, subsequently, the discourse of AIDS as a development problem.

Yet, despite this enhanced effort to combat the disease, the most recent update from UNAIDS on the global AIDS crises shows that the crisis is nowhere near abating in southern Africa (2006, 15). This begs the question of whether this paradigm shift is in fact making a significant difference in the fight against

AIDS, particularly in southern Africa where the interface of AIDS and development is most pronounced. To answer this question, the implications of this reconceptualisation need to be explored. Specifically, how cogently does *development* in its dominant form encapsulate the causes, context and consequences of HIV/AIDS? How do various interests and power relations that shape the notion of development play out in relation to the HIV/AIDS pandemic? Although the previous conceptualisation of AIDS as a health problem has extensively undergone this type of critique, AIDS as a development problem has received comparably little analytical attention.

What cannot be ignored in this paradigm shift is that the specific actors who hold a position of authority in the realm of development now have a privileged voice in the global governance of HIV/AIDS as a development problem. The large, multi- and bi-lateral organisations like the World Bank who are the drivers of development are firmly in a position of financial and intellectual authority to impose their interests and agendas on the global response to HIV/AIDS. As history unequivocally demonstrates, neoliberal economic development has been heavily promoted through the interventions undertaken by many these actors, while broad social welfare is a secondary objective assumed to be attained from the trickle-down effects of a thriving market-based economy. Therefore, by reconceptualising AIDS as a development problem, the main promoters of neoliberal development in the Third world are afforded a more direct role in the governance of the disease.

O'Manique has argued that neoliberalism underpinned the production of knowledge on AIDS as a health crisis and constricted opportunities for a comprehensive response that would address the wider socioeconomic impacts, as well as the immediate individual physiological concerns, allowed preoccupations with cost-effectiveness to override efforts to save as many lives and livelihoods possible, and placed the burden of prevention and care on individuals, rather than on communities and states (2004a). But to what extent does this paradigm shift resolve these barriers and allow for a global response that equitably incorporates the voices of all relevant actors at every level—from individuals and communities up to national governments and international organisations—and that effectively addresses all facets of the crisis?

Examining the HIV/AIDS crisis through a development lens that is heavily coated with growth-oriented neoliberalism reveals several problems for devising a successful response to the HIV/AIDS crisis. First, this reconceptualisation risks focusing overwhelmingly on the economic context of vulnerability, potentially suppressing an understanding of inequality and power relations as significant causes of vulnerability. Second, the actual mode of development currently dictating the nature of interventions, which often ignores the political context and bypasses governments in the implementation stage, limits the amount of agency individuals have toward certain unequal power relations that render them vulnerable. Finally, the influence of donor agencies' interests can conflict with the participatory style approaches that are needed to give individuals and communities agency in the fight against HIV/AIDS.

Singular focus on economic factors

Undoubtedly, the connections between poverty and vulnerability to HIV/AIDS are staggering, and merit the recognition provided by the paradigm shift towards AIDS as a development problem. That development projects and programmes need to recognise the pandemic as it relates to poverty alleviation efforts (and vice versa) is also undeniable. However, it is equally essential to recognise that the dynamic between poverty and HIV/AIDS is not entirely straightforward and that poverty, when conceived of in purely economic terms, is by no means the sole context in which HIV/AIDS spreads.

Despite the important insights arising from this paradigm shift, there is a risk of oversimplifying the causes of HIV/AIDS as a matter of one's economic status, and forgetting the crucial importance of other contextual factors, such as the unequal position of women in society and the processes of collective identity formation which are intrinsically tied to sexuality and therefore HIV transmission. This view of economic poverty as the chief determinant of vulnerability suggests that development itself is the necessary solution to the crisis. However, the complex dynamic between poverty and HIV/AIDS requires a more cautionary approach than simply scaling up current development efforts to lift people out of

poverty. Furthermore, addressing only the socioeconomic context of vulnerability without providing a sense of individual empowerment or agency with respect to the other important contextual factors will not be a sufficient response to the HIV/AIDS pandemic.

Unlike many development issues, HIV/AIDS does not exclusively affect the poor. All individuals, regardless of their socioeconomic status, are potentially vulnerable to HIV infection. This includes high-level politicians, cultural icons, bureaucrats, NGO volunteers as well as the (predominantly rural) poor. It is the poor who are the least likely to have access to medical facilities and AIDS drugs, and whose livelihoods are the most threatened by AIDS. However, the poor have not shown a uniform vulnerability to infection. As Bryceson, et al, point out in their study of AIDS in Malawi, prostitutes, despite being poor and having limited livelihood opportunities, have a “vested professional interest in adopting safe sex practices,” unlike women who engage in occasional transactional sex due to desperate circumstances and have very little ability to negotiate condom use (2004, 28).

HIV/AIDS is also impoverishing people not previously considered poor in unprecedented ways, as de Waal and Whiteside have argued (2003, 1235). While alleviating the widespread poverty in southern Africa, which is already immeasurably more difficult in the face of the AIDS crisis, will undoubtedly have a huge benefit for the fight against the pandemic, HIV/AIDS must not be mistaken as simply another development problem that will be solved with economic gains since the disease can so easily reverse this progression. Economic security will reduce the likelihood of certain livelihood strategies that increase one's risk of contracting HIV, such as transactional sex or long-distance travel for employment, which is often associated with extra-marital sexual activity. However, it does not address all aspects of vulnerability and fails to critically examine the relationship between development itself and vulnerability.

Conflating poverty as a source of vulnerability to HIV/AIDS with low levels of modern economic development, which evokes early modernisation theories of development, is a potential consequence of the reconceptualisation of AIDS as a development problem. However, the paradox of the epidemics in Botswana and South Africa, two of the most economically and politically advanced countries in southern Africa, challenges the narrow view that low economic development alone causes the AIDS crisis. Both of these nations' infection rates are amongst the highest in the world despite their comparatively high standards of living and health care capacity by southern Africa's standards (Bryceson et al. 2004, 16).

Alan Whiteside suggests that “HIV spreads among people at the margins of society, the poor and dispossessed” (2002, 314), which in turn indicates that these high prevalence rates are a consequence of the processes of marginalisation and income inequality resulting from rapid modernisation and development rather than of static economic conditions. The speed and scale of development in both countries was accompanied by the destruction of certain livelihood strategies that were central to the wellbeing of the large populations of poor rural agriculturists. The AIDS epidemic in the United States, which is disproportionately high among young African-Americans who account for 50% of new infections despite making up only 12% of the population, is a further example of the role of inequality and marginalisation, regardless of the level of national economic development, in fuelling the global crisis (UNAIDS 2006, 46). Undoubtedly, low economic status at a household or community level goes hand in hand with marginalisation and inequality, but it cannot be assumed that resolving only one of these elements of poverty will necessarily resolve the others.

The view of AIDS as a development problem is quite in line with the interests of major development institutions, as it reinforces their role as the saviours of the Third World. Furthermore, the threat that AIDS poses to development also deflects attention from the fact that development itself has been largely unsuccessful in most of southern Africa. However, the cases of Botswana and South Africa caution against treating development as a panacea to the HIV/AIDS crisis, particularly since neoliberal economic growth still dominates the development agenda, often at the expense of maintaining livelihoods. This is particularly apparent among the major development institutions, like USAID and the World Bank, which have become prominent advocates of the AIDS as a development problem discourse, and are major players in the global governance of the disease. The development aid they provide often entails unreasonable debts, which allows the imposition of structural adjustment programmes in the recipient country under the guise of economic development and modernisation. On top of marginalisation and

highly unequal income distribution, this has often led to eroding health care and social service provisioning in many countries, as well as diminished financial capacity at the state level available to fight HIV/AIDS. Although development institutions are quick to emphasise the poverty-HIV/AIDS connection, the underlying causes of poverty in the region, which unavoidably include structural adjustment and debt repayment, are not adequately recognised in the discourse of AIDS as a development problem.

Further challenging the construction of AIDS as a development problem is the fact that there are certain contextual factors of vulnerability that transcend socioeconomic groups, most notably the unequal position of women in society, and are not adequately addressed by development interventions. Culturally, and at times even legally, women are given a lower status in society in much of sub-Saharan Africa. This manifests itself in the greater likelihood of women to experience poverty and violence, and to be unable to negotiate safe sex, and thus be more vulnerable to HIV infection regardless of the socioeconomic group to which they belong. With infection rates two and a half times higher for women than men in the 15-24 years age group in sub-Saharan Africa, gender is itself a primary determinant of vulnerability (UNAIDS 2004, 8). Furthermore, it is not only poor women who face inequality and disempowerment with respect to their sexuality. Barnett and Blaikie have noted that in the Machakos region of Kenya, female schoolteachers who had relatively stable livelihoods and generally more knowledge of HIV/AIDS reported feeling unable to negotiate safe sex with their spouses, despite suspicions of infidelity (1992, 164-165).

Rather than engaging directly with the often taboo and loaded subject of sexuality, the construction of AIDS as a development problem places the emphasis on the socioeconomic context that shapes sexual behaviour and attitudes. While this permits a seemingly neutral avenue for addressing the spread of the disease without evoking the awkward or opprobrious stereotypes and misconceptions that permeated earlier discourses on AIDS, it overlooks certain key aspects of sexuality that are crucial to reducing vulnerability. According to Bryceson, et al., “[s]exual behaviour represents one of the most complex interplays of human activity and meaning. To interpret sexual behaviour and vulnerability to AIDS simply as the outcome of one’s economic standing would be reductionist in the extreme” (2004, 17). The various interests and power dynamics embedded in sexual behaviour and attitudes are not limited to the economic functions of production and reproduction, as constructed in this current discourse. Sexuality is also critical to individual and collective identity, social status, personal fulfilment and myriad other functions. While raising the economic standing of an individual may give them a certain amount of agency toward the productive and reproductive aspects of their sexuality, it will not directly provide empowerment with respect to the other functions, such as pleasure, spousal obligation, and affirming one’s identity or membership to a social group.

Proponents of the discourse of AIDS as a development problem frequently criticise the discourse of AIDS as a health problem for not integrating an understanding of the wider context and structural barriers into behavioural change approaches. Yet, this discourse implicitly assumes that behaviours and attitudes towards sexuality conducive to vulnerability will somehow resolve themselves through increased levels of development. In reality, the attitudes adopted towards HIV/AIDS are also a fundamental determinant of the effectiveness of any efforts to reduce vulnerability. For example, Bryceson, et al., note that pervasive attitudes of fatalism and denial in Malawi have inhibited the adoption of safer sex practices and at times even perpetuate risky behaviour (2004, 16). In many ways, this is not altogether a surprising finding, considering that there is widespread awareness that treatment to prolong one’s productive years after HIV infection does exist but is not accessible to the vast majority of people infected with HIV/AIDS because of trade regulations that privilege obscene prices for AIDS drugs over saving lives and maintaining livelihoods. This global inequality, as Boone and Batsell point out, is a much different reality than if no treatment existed (2001, 23). This alarming disposition towards riskier behaviour resulting from denial or fatalist attitudes regarding HIV/AIDS is not simply a matter of socioeconomics but is also related to the amount agency one has or believes they have towards their circumstances.

With any response to HIV/AIDS, including development interventions, “[t]he goal is to empower people to make decisions that reduce risks of infection or to stick to existing behaviours that have the same effect” (Barnett and Whiteside 2002, 333). Poverty reduction is an inherent and major part of any successful response, but it is essential that poverty reduction interventions do not compromise people’s and

communities' sense of empowerment over the process, nor over other factors that contribute to vulnerability.

The political dimension of HIV/AIDS

The political context of a region has a profound effect on the nature of its AIDS epidemic and on the response in a given region. Yet the dominant model of development tends to overlook the specific political context of a region as a primary variable determining the pertinence or suitability of interventions. While the role of governments in social and health service provisioning has been systematically reduced since the beginning of development in southern Africa, the current trend is to bypass governments all together in the implementation stage of development projects and programmes. Yet, the few examples of successful campaigns to reduce the spread of HIV/AIDS in African countries demonstrate unequivocally the importance of apposite political leadership.

Where the political context is acknowledged by development agents, it is generally for the legacies of government corruption and minimal levels of capacity, which has fostered the perception that privileging governments in development implementation is likely to do more harm than good. Macro-level development policies have therefore aimed to reduce government involvement in welfare and service provision, while championing the role of civil society in implementing development projects. In the same vein, the global governance of AIDS as a development problem has implicitly assumed that government corruption and lack of capacity has allowed the disease to escalate unchecked into a crisis of unfathomable magnitude. For instance, the World Bank's seminal report on the connections between HIV/AIDS and development identifies a lack of strong political commitment, inadequate capacity and competing priorities for governments, and certain pervasive cultural and religious beliefs as a few of the major barriers impeding mobilisation against the HIV/AIDS pandemic in the region (1999, 25-26). However, subsequent actions recommended by this report do not directly address these barriers, such as by offering means of building up capacity or stimulating leadership, nor their underlying causes. Instead, the actions recommended by the report centre on mobilising the private sector, including civil society, to circumvent the lack of government leadership and capacity in the fight HIV/AIDS (1999, 26-41).

Without question, there are many cases where government recognition of the severity of the HIV/AIDS crisis has been callously and devastatingly slow, such as in Zimbabwe where the Mugabe regime denied the existence of a problem in the face of indisputable evidence and actively impeded NGOs efforts (Boone & Batsell 2001: 10). In other cases, such as Uganda and Senegal, government efforts have been praised for their widespread success and effective collaboration with civil society (Putzel 2004: 1132). Nonetheless, these variations in governmental responses are not well understood and have not informed the creation of the 'one-size-fits-all', stand-alone National AIDS Commissions (NACs) which governments must adopt in order to receive and coordinate funding for HIV/AIDS interventions from donor agencies like the World Bank's Multi-Country AIDS Programme (MAP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Many laudable characteristics figure into the structure of the NACs, including partnership with civil society organisations, decentralised and participatory approaches to service delivery, and multi-sectoral responses intended to address the socioeconomic determinants of vulnerability (Putzel 2004, 1131). Within this model, governments have a putative role as visionaries of the Commissions but are not actually involved in much of the implementation. Putzel, however, has argued that the NAC model is effectively an attempt "to replace what is essentially a *political challenge* of prioritising HIV/AIDS in government and non-government sectors with an *organizational fix*" (2004: 1137 [emphasis not added]). In other words, the NAC model is an attempt to replicate the success of Uganda and Senegal by transposing a specific framework without taking into account whether any political will or leadership exists, or how it will conform to different political contexts, such as varying levels of bureaucracy and the nature of the relationship between governments and civil society, which may constrain their effectiveness.

While it may not sufficient on its own to ensure a successful fight against HIV/AIDS, there is little doubt that political leadership and commitment at all levels of society were integral to efforts to reduce of

HIV/AIDS prevalence in countries like Uganda, Thailand and Senegal (Putzel 2004, 1132). However, there is little incentive within the NAC model to stimulate the necessary levels of enthusiasm and mobilisation amongst the key figures in the political scene. The NAC model assumes that creating space for civil society organisations will instigate or replace action at the political level. Yet, in the case of Uganda, the motivation for the widespread social mobilisation against HIV/AIDS originated at the highest level of government, which in turn mobilised and empowered its population and civil society (Putzel 2004, 1135; Boone and Batsell 2001, 13). The political sphere is one in which the many of power relations, from the interpersonal to the structural, that influence peoples ability to negotiate the circumstances rendering them vulnerable to HIV/AIDS and its impacts are often created and defined. Strong political leadership, as demonstrated by Uganda, affords an opportunity for many of these power relationships to be directly addressed, and thereby contributing to the prevention and mitigation of the disease.

In particular, political leadership in the HIV/AIDS crisis can have a positive (or negative) influence on reducing the stigmatisation of people living with HIV/AIDS, countering unequal gender relations, and promoting livelihood-friendly socioeconomic development. Stigmatisation can take many forms and vary widely between societies and culture; however, for the most part stigmatisation towards HIV/AIDS involves some form of social denial about the disease, the way it spreads or certain prevention methods, and exclusion of those affected by it. The impacts of stigmatisation, regardless of its form, can severely constrict many strategies to combat the pandemic (Altman 2006, 86-88). For instance, stigmatisation can potentially inhibit people from seeking voluntary counseling and testing (VCT) or attending AIDS education events. The use of condoms has been stigmatised by some religious NGOs. People living with HIV/AIDS may find that social exclusion creates difficulties for pursuing critical livelihood objectives, or obtaining agricultural extension services. Stigmatisation also risks limiting personal empowerment and collective mobilisation around the disease, such as negotiating safe sex or volunteering with HIV/AIDS-related non-governmental organisations. Although little comprehensive information on the effectiveness of different types of campaigns against stigmatisation and discrimination exists, the importance of action discouraging stigmatisation at the highest levels is recognised (UNAIDS 2006, 196-197).

Government reaction to the disease is a crucial determinant of how HIV/AIDS is perceived by wider society and in preventing discrimination and other human rights abuses against people living with HIV/AIDS, particularly where political figures are afforded a high level of moral authority in society. According to Barnett and Whiteside,

A key feature of Uganda's response was leadership. This ensured that AIDS was consistently on agendas and people were not stigmatised. It began with President Museveni talking openly and frankly about AIDS as early as 1986. He insisted that AIDS be put on the political agenda at all levels. (2002, 320)

Essentially, when political leaders are willing to force recognition of HIV/AIDS on society, they can do so with a considerable degree of expediency and authority. On the other hand, government denial of the crisis or even the disease itself has been a common feature in many countries where infection rates are disconcertingly high, such as Zimbabwe and South Africa (Altman 2006, 261). The responsibility for enforcing human rights and tackling the discrimination faced by people living with HIV/AIDS in certain circumstances also lies primarily with governments. Thus, commitment by governments and political leaders is fundamental to reducing stigmatisation and to opening up spaces for individual and social empowerment against HIV/AIDS.

The nature of gender relations and the overall status of women in society as a factor of vulnerability are also impacted by the political context, and especially by the willingness of political leaders to put gender rights at the forefront of the fight against HIV/AIDS. Though it is widely acknowledged that the unequal status of women is a major source of their vulnerability to infection and the negative impacts, advancing the status of women and mainstreaming gender issues into the fight against HIV/AIDS has not been a key requirement for obtaining funds by the major donor agencies. The ability of political leaders to either reinforce or counter deeply embedded notions of gender roles and relations is significant, and needs to be taken into account. Reforming property rights, enforcing measures to counter violence against women and ensuring universal education are a few practical means for supporting gender equality, as indicated by UNAIDS (2006, 136-137).

Correspondingly, political leadership that is negligent of gender rights can reinforce unequal power relations that render women distinctly more vulnerable to HIV/AIDS and its impacts. For instance, women were notoriously exploited in Malawi as sexual servants to high-ranking government officials under President Banda, and as 'dancing girls' at political functions to praise Muluzi's regime (Booth et al. 2006, 11). The opportunities for female empowerment over their sexuality and HIV/AIDS amidst this manifest and normalised exploitation at the highest level of authority are obviously greatly constricted. Although the socioeconomic status of women also contributes to their vulnerability, it is unlikely that achieving greater socioeconomic and livelihood sustainability will sufficiently reduce women's vulnerability if they remain in a socially and politically ascribed position of inequality.

Donor influences and the civil society model for intervention

According to de Waal, "[t]he HIV/AIDS pandemic has unfolded at a time when the dominant approach to social action in Africa has been an NGO model" (2003, 18). In keeping with the preference of bypassing the state, development institutions have favoured the private sphere, in the form NGOs and other civil society organisations, for the implementation of HIV/AIDS interventions. This preference is reflected in the National AIDS Commission frameworks, which emphasise civil society participation in the policy and strategy formation and as a key means of combating HIV/AIDS. This aspect of the NAC framework has been widely praised for empowering people living with HIV/AIDS by providing a means of participating in the policy formation processes.

In practice, however, the strength and effectiveness of this agency over the governance of the crisis afforded to people through the civil society model of development is questionable. The current trend in development has not displaced the ideology and interests that have dominated development thinking since the mid-20th century. Rather, in the fight against HIV/AIDS, the role of civil society in development will often act in symbiosis with the interests and objectives of the large donor agencies that continue to pursue large-scale, top-down, neoliberal economic development and modernisation. The influence of these donor interests can be in direct competition with those of the communities and people civil society organisations supposedly represent in the governance of HIV/AIDS.

The reconceptualisation of AIDS as a development problem provided an entry point for a host of international actors, including multi- and bilateral donor agencies and development institutions, non-governmental organisations and UN agencies, to implicate themselves as major players in the governance of the crisis. While these actors have already permeated African society and governance structures in the name of 'development', they have been able to re-justify their legitimacy and existence in the fight of HIV/AIDS. This proliferation of actors can open up avenues of agency that may not exist otherwise, but it can also create further barriers for empowerment and ownership of the governance process by producing new layers of power dynamics complicated by a variety of interests and objectives that the voice of the people first must pass through to influence the global governance of HIV/AIDS.

In general, the increased participation of civil society organisations, which includes NGOs, formal or informal community-based organisations, and religious groups, in this governance process has been lauded as a significant step towards empowering people living with HIV/AIDS. Local civil society organisations in southern Africa have been at the forefront of the most innovative, immediate and successful 'on-the-ground' responses to the HIV/AIDS crisis and have been addressing the wider socioeconomic impacts of the disease well before the reconceptualisation of AIDS as a development problem (Rau 2006, 289). The close connection to local populations and communities, and the wealth of experience and expertise of civil society organisations presents an indispensable opportunity to inform the global response to the crisis. However, in practice the level of participation and agency actually afforded to these organisations within the global governance of HIV/AIDS has been disappointingly inadequate.

In penetrating the governance of HIV/AIDS, large multi- and bilateral development institutions like the World Bank and USAID, have retained their hegemonic positions as development *experts*. Their authority and control over development knowledge and financial resources is threatened by and greatly limits the

space for the alternate perspectives, experiences, methods and practices that civil society organisations contribute (Rau 2006, 289). Even where donor agencies have been willing in principle to entrust civil society organisations with a greater level of responsibility and participation, Rau suggests that the diffuse, small-scale and flexible operational nature of many community-based civil society organisations that engenders much of their success in combating HIV/AIDS is often incompatible with their large-scale, bureaucratic mechanisms and procedures (2006, 290). Therefore, civil society organisations that are more bureaucratic in nature, or that do not have community connections are often at an advantage over grassroots initiatives in terms of access to policy-making procedures and funding, despite the fact that they will not necessarily contribute to the participation of, or provide a sense of agency to local communities and people living with HIV/AIDS.

Though these development institutions have promoted community participation and grassroots initiatives at a rhetorical level, the actual role configured for civil society organisations has been primarily project implementation rather than policy-making. As described by Seckinelgin, “[c]ivil society, in this system, is by and large constructed into a resource category to be utilized as an efficient and effective way to deal with the disease at the community level. In terms of this policy context, the role of civil society is to act as a conduit between policy structures and the people” (2005, 356). In this sense, the involvement of civil society organisations in project implementation is beneficial to the drivers of mainstream development, as it reinforces their hierarchy in the development field and maintains the decidedly neoliberal preference for using private mechanisms of health and social service delivery. Consequently, the knowledge transfer that occurs in this system is predominantly unidirectional, flowing from the development institutions to civil society.

Further compromising the interests and autonomy of civil society organisations is their financial dependency on the massive funds that have been made available concomitant to the shift in discourse from AIDS as a health problem to AIDS as a development problem. This funding structure for HIV/AIDS interventions limits the types of projects that civil society organisations can undertake and fundamentally alters the object of their accountability, from the communities they work to the donors who control their funding. Hamoudi and Sachs have pointed out that donors tend to have a preference for highly visible, small-scale and short-term projects, which rarely make as significant an impact as warranted, over scaling-up and continuing existing operations (2002, 690). These types of projects do not draw upon the recognised strengths of community-based organisations, such as the ability to reach the most marginalised communities and households. In fact, the tendency for interventions to be clustered around easily accessible and stable urban areas is commonly noted (O'Manique 2004a, 65; Scott 2000, 581).

Consistent with the adoption of the civil society model of implementation is the dubious claim by development institutions to be adopting a more a progressive, participatory approach to development that is sensitive to livelihood demands and aware of the potential inequalities arising from macro-economic development. In particular, the sustainable livelihoods approach to poverty alleviation has gained favour with the World Bank and other bi- and multi-lateral agencies (Bryceson 2004, 623). From an analytical perspective, the sustainable livelihoods approach offers invaluable insight into how households, particularly the rural poor, maintain their way of life by utilising various forms of capital, how they cope with shocks like droughts or warfare, and how wider forces such as national debt, structural adjustment or inequalities in the global market impact livelihoods. This approach places household wellbeing at the centre of analysis prioritises environmental, social and economic sustainability over economic growth.

Operationally, however, livelihoods-based development projects are discouragingly inward looking and do not adequately challenge or address these wider forces when implemented by the same development agencies that directly or indirectly contribute to these forces. Rather, development interventions using a livelihoods approach tend to be exclusively project-oriented, and deflect criticism from over-arching neoliberal policies of development by emphasising and utilising the different endogenous forms of capital and resources that households can draw on to sustain their livelihoods or to lift themselves out of poverty. Such resources include human, social, financial, natural and physical capital.

The logic of this approach is comprised by a reality of decreasing employment opportunities, a continually shrinking land base, and a contraction of nearly all other resources available to an increasing number of

poor. In Bryceson's words, this approach "represents a positive step forward compared to almost two decades of SAP and economic liberalisation policies" but "has been limited by its lack of a realistic acknowledgement of the impact of neo-liberalist policies and current world market conditions, leaving avenues for achieving poverty reduction disturbingly vague" (2004, 623). In a sense, livelihoods approaches can help buffer or soften the effects of neoliberal development policies on the poorest and marginalised sections of society, but provide no opportunity to challenge them. They also allow agencies like the World Bank to retain their moral and institutional authority over development in southern Africa while at the same time continuing to promote neoliberalism through debilitating debt repayments and structural adjustment policies.

Further compromising the opportunities for empowerment under the current governance of HIV/AIDS is the exploitation of the notion of coping strategies in neoliberal development strategies. Underscoring the livelihoods approach is the belief that households can cope with shocks, such as droughts, by relying all their different forms of capital (Bryceson 2004, 622). With respect to the AIDS crisis, there is a widespread belief that a putative abundance of social capital in Africa society will absorb the burden of caring for those who are sick and orphaned (Poku 2005, 170; Rugalema 2000, 540). While there are a number of studies documenting the tendency for communities and extended families to provide for people living with HIV/AIDS, the viability of relying on social capital is quite overestimated and the cost is greatly underestimated (Rau 2006, 286).

It is generally recognised that diversifying livelihoods options or employing coping strategies will require some tradeoff between types of capital. However, it is becoming increasingly evident that the burdens of HIV/AIDS are overwhelming people's abilities to meet their essential livelihood demands, such as ensuring adequate nutritional intake or maintaining one's farm, because these tradeoffs are too great. Rugalema's study of the effectiveness of coping strategies in the face of AIDS, which includes relying heavily on social connections to care for those who are ill or orphaned and selling off irreplaceable assets like livestock to pay for medical expenses, argues that people are not in fact *coping* because they are not actually recovering from their efforts to mitigate the impacts of AIDS (2000). The rising number of dependents is also stretching the limited resources of poor households beyond sustainable levels.

The irrationally high expectation of care that the global governance of HIV/AIDS places on poor and marginalised communities and people can be an obstacle in itself to other forms of social mobilisation and empowerment. Not surprisingly, this burden often falls directly on women, whose work in general has been chronically underestimated and undervalued, since they are the traditional caregivers in society. As Baylies suggests, relying too greatly on women to perform the caregiver role can be very disempowering since it may reinforce gender stereotypes that may prevent them from mobilising in ways that will allow them to renegotiate the power relations that make them the group most vulnerable to HIV/AIDS (2000, 19). Similarly, in context of HIV/AIDS micro-credit schemes and other poverty alleviation approaches that intend to provide opportunities for women to expand their capital also risk demanding too much of women, which can further overwhelm and disempower women (O'Manique 2004a, 71).

Although the declarations of renewed commitment to ending poverty as a means to fight HIV/AIDS by large development institutions such as the World Bank are encouraging, this commitment will only be effective if structural barriers to poverty alleviation are removed and if corresponding problems of inequality and marginalisation are equally addressed. Simply sustaining livelihoods and mitigating the impacts of HIV/AIDS cannot be the end goal of development interventions if the objective is to substantially decrease vulnerability to HIV/AIDS and to increase the wellbeing of people and communities affected by HIV/AIDS.

Conclusion

HIV/AIDS is inexorably a development problem. But it is also a health problem, a cultural problem, a political problem, a racialised problem, a gender problem, an agricultural problem, and a postcolonial problem. The complexity and facets of the HIV/AIDS crisis are almost inestimable. To reduce the spread of and vulnerability to HIV/AIDS, the resources of development institutions are essential, but cannot alone

address all facets of the crisis. The very characteristics of large development institutions that give them their authority in the governance of AIDS as a development problem—bureaucracy, hierarchy and dogmatism—are those which inhibit them from penetrating the socio-cultural and psychological space where some of the most crucial decisions and actions affecting the spread of the disease take place. The realm of sexuality is one where desire, identity, tradition, rebellion, pleasure, violence and fulfilment intersect anarchically with one another, and is largely impenetrable to inflexible, top-down approaches put forth by culturally exogenous actors. The less-than-successful behavioural modification approaches advocated by international health experts early on in the crisis are illustrative of this fact.

Yet, large-scale development institutions have been unwilling to cede the position of authority and expertise in the governance of HIV/AIDS to organic grassroots initiatives that locate the centres of knowledge production directly within the cultures and communities of people affected by HIV/AIDS. Neither have these institutions been willing to rethink their own development agendas and objectives in the face of the pandemic. In essence, the paradigm shift in AIDS thinking has not sufficiently opened up opportunities for local agency at the global level.

The current model of development places the overwhelming burden of coping with the multiple afflictions of AIDS and food insecurity on households, those with the least amount of resources and influence to negotiate their circumstances. In the face of this crisis, the role of development needs to refocus its objectives toward ensuring the continued subsistence and viability of rural households. The connections between the pandemic and the numerous facets of poverty—inequality, marginalisation, malnutrition, lack of access to health and social services—will deepen if they are not prioritised, and the crisis will inevitably continue to deepen. Gender inequalities in particular will be aggravated by the current approach. The responsibility of these burdens generally rests with the female heads of household and often results in the reinforcement of gendered roles which may be greatly disempowering for women.

Development institutions do, however, have a decisive role to play in fighting the HIV/AIDS crisis. In addition to financing and helping scale-up local initiatives, the influence and presumed expertise of these institutions are necessary to alter to the global context of inequality and poverty that are insurmountable barriers to agency vis-à-vis HIV/AIDS in southern Africa. Institutions like the World Bank are in a position to change the global consensus on crucial matters such as debt relief and patent laws restricting generic competition of AIDS drugs, which could potentially facilitate widespread endogenous initiatives to combat HIV/AIDS. In fact, it is increasingly recognised that HIV/AIDS initiatives hold significant potential to coalesce with and reinforce other social movements, such as gender, food sovereignty and human rights movements (Bryceson et al. 2004, 2; Baylies & Bujra 2000, 188). At the moment, unfortunately, these issues have not entered significantly into discourse of AIDS as a development problem.

Bibliography

- Altman, Dennis. 2006. Taboos and denial in government responses. *International Affairs*, 82(2): 257-268.
- Arndt, Channing, and Jeffrey D. Lewis. 2001. The HIV/AIDS pandemic in South Africa: Sectoral impacts and unemployment. *Journal of International Development*, 13(4): 427-449.
- Barnett, Tony, and Piers Blaikie. 1992. *AIDS in Africa its present and future impact*. New York: Guilford Press.
- Barnett, Tony, and Alan Whiteside. 2002. *AIDS in the Twenty-First Century disease and globalization*. New York: Palgrave MacMillan.
- Baylies, Carolyn. 2000. Perspectives on gender and AIDS in Africa. In *AIDS, sexuality and gender in Africa collective strategies and struggles in Tanzania and Zambia*, ed. Carolyn Baylies and Janet Bujra, 1-24. New York: Routledge, New York.
- Baylies, Carolyn, and Janet Bujra. 2000. The struggle continues: Some conclusions. In *AIDS, sexuality and gender in Africa collective strategies and struggles in Tanzania and Zambia*, ed. Carolyn Baylies and Janet Bujra, 174-197. New York: Routledge, New York.
- Boone, Catherine, and Jake Batsell. 2001. Politics and AIDS in Africa: Research agendas in political science and international relations. *Africa Today* 5: 3-33.
- Booth, David, Diana Cammack, Jane Harrigan, Edge Kanyongolo, Mike Mataure, and Naomi Ngwira. 2006. *Drivers of change and development in Malawi*. ODI Working Paper 261.
- Bryceson, Deborah Fahy. 2004. Agrarian vista or vortex: African rural livelihood policies. *Review of African Political Economy* 102: 617-629.
- Bryceson, Deborah Fahy, Jodie Fonseca, and John Kadzandira. 2004. *Social pathways from the HIV/AIDS deadlock of disease, denial and desperation in rural Malawi*. CARE and Renewal Report.
- de Waal, Alex. 2003. How will HIV/AIDS transform African governance? *African Affairs* 102: 1-23.
- de Waal, Alex, and Alan Whiteside. 2003. New variant famine: AIDS and food crisis in southern Africa. *Lancet* 362: 1234-1237.
- Dixon, Simon, Scott McDonald and Jennifer Roberts. 2001. HIV/AIDS and development in Africa. *Journal of International Development* 13(4): 381-389.
- Fredland, Richard A. 1998. AIDS and development: An inverse correlation? *The Journal of Modern African Studies* 36(4): 547-568.
- Gillespie, Stuart. 1989. Potential impact of AIDS on farming systems: A case study from Rwanda. *Land Use Policy* 6: 301-312.
- Haddad, Lawrence, and Stuart Gillespie. 2001. Effective food and nutrition policy responses to HIV/AIDS: What we know and what we need to know. *Journal of International Development* 13: 487-511.
- Hamoudi, Amar A, and Jeffrey D. Sachs. 2002. The economics of AIDS in Africa. In *AIDS in Africa*, ed. Max Essex, Souleymane Mboup, Phyllis J. Kanki, Richard G. Marlink, and Sheila D. Tlou, 676-694. New York: Kluwer Academic/Plenum Publishers.

O'Manique, Colleen. 2004a. Neoliberalism and AIDS Crisis in Sub-Saharan Africa Globalization's Pandemic. New York: Palgrave MacMillan.

O'Manique, Colleen. 2004b. Global neoliberalism and AIDS policy: International responses to sub-Saharan Africa's pandemic. *Studies in Political Economy* 73: 47-68.

Poku, Nana K. 2005. *AIDS in Africa How the Poor are Dying*. Cambridge: Polity Press.

Putzel, James. 2004. The Global fight against AIDS: How adequate are the National Commissions? *Journal of International Development* 16: 1129-1140.

Rau, Bill. 2006. The politics of civil society in confronting HIV/AIDS. *International Affairs* 82(2): 285-292.

Rugalema, Gabriel. 2000. Coping or struggling? A journey into the impact of HIV/AIDS in southern Africa. *Review of African Political Economy* 27(86): 537-545.

Scott, Guy. 2000. Political will, political economy & the AIDS industry in Zambia. *Review of African Political Economy* 27(86): 577-582.

Seckinelgin, Hakan. 2005. A global disease and its governance: HIV/AIDS in sub-Saharan Africa and the agency of NGOs. *Global Governance* 11: 351-368.

UNAIDS. 2006. *Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2004. *Facing the future together: Report of the Secretary General's Task Force on Women, Girls and HIV/AIDS in southern Africa*. Geneva: UNAIDS.

UNDP. 2005. *Hoping and coping a call for action the capacity challenge of HIV/AIDS in least developed countries*. Geneva: UNDP.

Whiteside, Alan. 2002. Poverty and HIV/AIDS in Africa. *Third World Quarterly* 23(2): 313-332.

World Bank. 1999. *Intensifying action against HIV/AIDS in Africa responding to a development crisis*. Geneva: World Bank.